

DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH CARE QUALITY ASSESSMENT

RELEASE FORM
NEW JERSEY NON-CONFIDENTIAL UNIFORM BILLING DATA FILES

Conditions for release of the New Jersey data files by Health Care Quality Assessment:

I, _____,

representing _____,

am requesting the uniform billing (UB) year-to-date data files for the year(s):
_____.

from the Health Care Quality Assessment program in the Department of Health and Senior Services (Department).

I agree that these files will be in the custody and maintained by
_____.

and will not be released to any other organization or individual without the prior written approval of the Department's Health Care Quality Assessment program.

I further agree that no attempt will be made to identify specific patients or physicians whose records are included in these files, or link information from any other source to records for specific patients or physicians.

No listing of information from individual records will be published or otherwise released by the holder of these files.

I understand that any violation of the above conditions may result in prosecution under all relevant State and Federal Laws.

(Signature)

Representative of:

(Name) (Date)

For Health Care Quality Assessment:

(Signature) (Date)